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Health Care Reform Implementation Council
Office of the Governor
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Chicago, Illinois 60601

Submitted Via State Portal:
http:www.healthcarereform.Illinois.gov

Dear Sir or Madam:

UnitedHealth Group is pleased to provide the Governor's Health Care Reform Implementation Council ("Council") our comments to some of the Request for Information regarding Health Benefit Exchanges. We welcome the opportunity for constructive dialogue regarding the development of Exchanges and the efforts of the Council.

UnitedHealth Group is dedicated to making our nation's health care system work better. We serve 70 million Americans, funding and arranging health care on behalf of individuals, employers and governments, in partnership with more than 5,000 hospitals and 650,000 physicians, nurses and other health professionals. As America's most diversified health and well-being company, we serve many of the country's most respected employers. Recognized as America's most innovative company in our industry by *Fortune* magazine, we bring innovative health care to scale to help create a modern health care system that is more accessible, affordable and personalized for all Americans. It is this experience that is the basis upon which we offer the following comments and recommendations to ensure that innovation and flexibility continue to thrive in the health care marketplace.

The comments offered below are intended to promote the development and execution of successful State-based health insurance Exchanges. Modernizing health care requires empowering consumers to make more informed health care choices, and we believe that effectively implemented State-based health insurance Exchanges have the potential to help them do so. Easy-to-use decision tools can help consumers make meaningful

comparisons and select plans that are appropriate for their financial and health needs and preferences.

Questions Related to Functions of a Health Benefit Exchange

Q: What advantages will Illinois see in operating its own Exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

Q: What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?

We believe that Exchanges should fundamentally be State-based to ensure that they are responsive to characteristics unique to the State, such as the specific dynamics of the individual and small group markets and the need to interface with the State's public programs. The State-based Exchanges will benefit from uniform federal standards in areas where variation at the State level would add unnecessary complexity, such as risk adjustment mechanisms, quality improvement measurements, and uniform data transaction standards. We also believe that State-based Exchanges can be appropriately tailored to create an efficient marketplace in Illinois by seeking to avoid duplication of existing State regulatory functions regarding rate review, licensing, and market conduct, and by relying to the extent possible on existing review standards established by national accreditation agencies – such as NCQA -- for use in the health plan certification process.

An Illinois-created Exchange can achieve the goals of being responsive to local market dynamics, making it easier for consumers to navigate a broad array of coverage options, make informed decisions, and obtain coverage, while also facilitating eligibility determinations and effective coordination with the State Medicaid and CHIP programs.

Q: What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

Ideally, Exchanges should enhance competition, promote ongoing innovation, and increase consumer choice. To best achieve these goals, we believe that all qualified health plans should be permitted to participate in the Exchange, and participating health plans should be encouraged to differentiate their plan offerings to appeal to a wide variety of consumers with different needs

and preferences, while still offering plan designs that are consistent with federal standards regarding specified actuarial values.

Questions Related to Structure and Governance

Q: If Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

We believe that Exchange governing boards would benefit from broad constituent representation from a wide range of stakeholders, including health plans, consumer representatives, employers and providers. Each of these stakeholders brings a unique perspective and expertise to the oversight of the Exchange to ensure that it accomplishes its goals by taking into account the input of all affected interests. We also believe that establishing the Exchange as an independent public authority will both promote transparency to the public and limit politicized decision making, to the ultimate benefit of consumers and stability of the health insurance marketplace.

Questions Related to the External Market and Addressing Adverse Selection

Q: Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

We believe that preserving a market outside the Exchanges is not only beneficial for consumers, but is also supported by the express language of PPACA. Specifically, Section 1312 of the law outlines clear Congressional intent that consumers should be empowered to enroll or select a plan outside of an Exchange, and that Exchanges should be voluntary. Exchanges should serve to supplement, but not replace, the existing small group and individual markets to enhance competition and increase consumer choice. We believe that eliminating the external individual market will only serve to reduce competition, stifle innovation and lessen the ability of consumers to purchase insurance plans designed to fit their specific needs.

Q: What other mechanisms to mitigate "adverse selection" (i.e. requiring the same rules for plans sold inside and outside the Exchange) should the state consider implementing as part of an Exchange?

The Patient Protection and Affordable Care Act (PPACA) already provides a number of mechanisms to mitigate adverse selection against an Exchange. This includes the equal application of health care reform requirements to insurers operating inside as well as outside the Exchange, including:

- Adjusted Community Rating rules (adjusted only by age, tobacco use, geography, and family status);
- Individual and small group plans must cover the same essential health benefits;
- Limits on individual out-of-pocket cost-sharing limits;
- Treating all individuals as part of one risk pool (and must do the same for small group enrollees);
- Charging the same premium rates for a plan offered inside and outside the Exchange; and
- The operation of the risk adjustment and reinsurance programs.

Perhaps the most significant protection against adverse selection against the Exchange is the fact that Federal subsidies are only available through the Exchange. The result will be that the majority of the individuals in the non-group market will purchase through the Exchange, thereby helping to ensure a balanced risk pool.

Ultimately, the viability of the non-group market will be highly dependent on the development of open enrollment rules, inside and outside the Exchange, that encourage consumers to obtain and maintain continuous coverage.

Q: What rules (if any) should the State consider as part of establishing the open enrollment period?

Open enrollment period rules that create an incentive for consumers to maintain continuous coverage will be a critical element in determining whether Exchanges attract a stable risk pool of members or suffer from severe adverse selection. Both initial and ongoing open enrollment periods should be structured to encourage consumers not to delay seeking coverage until the point they will incur high health care costs and then cease coverage immediately thereafter.

A June 2010 study by Oliver Wyman on behalf of the Health Care Access Bureau of the Massachusetts Division of Insurance documented that the lack of a structured open enrollment period in the Massachusetts non-group market led to an increase in adverse selection that increased cost for the entire market.

Some of the specific techniques that Exchanges should consider to mitigate the possibility of adverse selection include:

- Limiting the open enrollment to a single 30 to 45 day timeframe each year;
- Prohibiting plan changes between open enrollment periods and limiting increases in coverage at open enrollment to one step (e.g. bronze to silver) per year;
- Providing clear rules about the limited exceptions that should be allowed for individuals to enroll outside the open enrollment period;
- Establishing staggered open enrollment periods tied to a policyholder's date of birth to distribute the administrative process evenly through out the year.

With respect to programs that have income eligibility criteria, we recommend establishing an enrollment and eligibility determination process that promotes continuity of coverage and reduces shifts between types of coverage and subsidy levels. This will promote stability and continuous care management for consumers and ease of administration for states and participating health insurance carriers.

Q: The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of the Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?

We believe that the framework for a risk adjustment methodology for Exchanges should be established at the national level to ensure uniform standards and promote efficiency and consistency. The American Academy of Actuaries should be consulted for its recommendations on federal standards for risk adjustment, reinsurance, and risk corridor mechanisms. We believe that it will be important for the reinsurance, risk adjustment, and risk corridor processes to be defined well in advance of the date that Exchanges become operational, be effectively integrated, promote stability in pricing, and not penalize efficient health plans that price responsibly to support health plans that are either inefficient or price irresponsibly.

Q: If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?

The numerous provisions in PPACA that protect against adverse selection against the Exchange would tend to make the adoption of additional rules unnecessary. Specifically, requiring the same rules apply to plans sold inside and outside the Exchange or requiring that the same plans be sold inside and outside the Exchange without exception would likely serve to reduce consumer choice and competition.

For example, some licensed health plans may not meet the requirements to become Qualified Health Plans (QHPs). A rule that these plans must meet the QHP requirements to compete in the outside market could theoretically exclude them from competing in the state. Regarding plan design requirements, Exchanges will likely need to put some limits on the number of plan designs available through the Exchange for practical reasons. However, imposing these same limits on the outside market would also reduce consumer choice and limit innovation in the market.

Questions Related to Structure of the Exchange Marketplace

Q: Should Illinois operate one Exchange or two separate Exchanges for the individual and small group markets? Why?

In general, while states may wish to share Exchange infrastructure between the individual and small group markets to achieve administrative efficiencies, we believe that maintaining separate individual and small group markets results in ease of administration, more accurate risk pooling and greater likelihood of ensuring widespread health plan participation.

The individual market generally has a higher risk profile than the Small Group market, presenting a greater potential for adverse risk selection and inherently higher administrative costs for individual coverage compared to small group coverage. Small groups have different eligibility, enrollment and general administration needs than individuals, and employers with more than 20 employees generally require a different type of customer support service. A likely result of combining the two markets would be to increase the rates for small groups, which could destabilize the small group market. Maintaining separate risk pools has the potential to encourage a full spectrum of participating health plans that have core competencies in dealing with distinctly different Exchange populations.

Q: What should the Illinois definition of small employer be for initial Exchange participation in 2014?

Under PPACA, Illinois has the authority to choose to limit small groups to those with 50 or fewer employees for plan years beginning before January 1, 2016. We believe that Exchanges would be better served by selecting 50 employees as the initial size limit for the small group market for several important reasons. First, the 51+ employer group market is already very competitive and enjoys significant market leverage, resulting in high health insurance offer rates. Limiting the small group market to under 50 employee groups will not only minimize market disruption, but will also avoid overtaxing state administrative burdens in operating the small business Exchange, particularly during the early years. Second, limiting the market to groups with fewer than 50 employees also decreases the risk of adverse selection. Groups over 50 employees typically have the option to self-insure their benefits, and it is reasonable to expect that the lowest cost groups would opt to self-insure and the highest cost groups would find the community rates within the Exchange to be most attractive, making products within the Exchange increasingly more expensive for those small groups electing coverage.

Q: Should Illinois consider setting any conditions for employer participation in the SHOP Exchange (e.g. minimum percent of employees participating, minimum employer contribution)?

Generally, we believe that some form of participation requirement makes sense for employer groups within the Exchange to assure a balanced risk pool. Requiring all employees of an employer within the SHOP Exchange to purchase from within one actuarial level also helps to keep costs down by mitigating adverse selection.

Q: Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in2016? Are there any special considerations for including this group of which the State should be aware?

We do not believe that the Exchanges should be expanded to large employers with more than 100 employees. Large employers generally enjoy market leverage and economies of scale that permit them to select and enroll in high quality private health plans for their employees that fit their needs at competitive prices. Further, large employers are generally either self-funded or fully-experience rated (meaning that their insurance rates are based largely on their actual costs). Making large employers eligible for the Exchange increases the potential for adverse selection within the Exchange, since only the highest-cost large employers can be expected to find the

adjusted community rates within the Exchange to be attractive relative to their other marketplace options.

Questions Related to Self-Sustaining Financing for the Exchange

Q: How should Exchange operations be financed, after federal financial support ends on December 31, 2014?

As governing boards develop financial plans to meet the requirement that Exchanges be self-supporting by 2015, we believe that the State should consider the imposition of user fees for those purchasing coverage through the Exchange, similar to the fees successfully established by other state Exchanges to support their ongoing operations. If other assessments are to be explored to support the Exchange, we believe they should be broad-based and levied on all health care industry participants who benefit from the Exchange, including providers, health plans, employers, agencies and other constituencies.

Questions Related to Eligibility Determination

Q: How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?

Coordinated eligibility and enrollment efforts between Medicaid, CHIP and Exchanges will help promote continuity and stability for consumers, and this will in turn help streamline the process of eligibility and enrollment.

An essential function of the Exchange will be the ability to take an individual or household and based on their Modified Adjusted Gross Income, direct the person to the program and subsidy for which they qualify. A challenge in achieving the goal of seamless coordination will be the fact that people's incomes and/or circumstances may change.

In the design of eligibility systems, eligibility rules are the foundation of the systems. A simplified set of eligibility rules should drive the system design. Steps should be taken to ease consumer navigation and administrative burden, including a standard template to capture personal information and pre-populating forms with known information. Data should be shared across community and state programs, and an individual's Social Security Number or unique ID number should link to federal and state data resources and assistance programs. Illinois should also think creatively about establishing community hubs for eligibility verification (e.g., contract with drug stores to

be an intake point) and coordinating with utility providers to help verify member addresses.

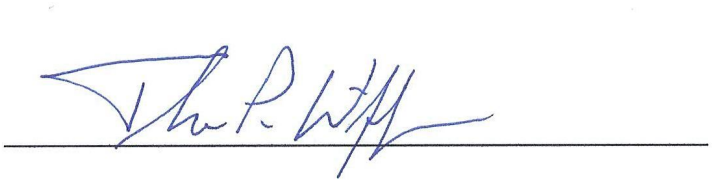
Illinois can leverage existing enrollment tools by linking to state Medicaid and CHIP enrollment portals from the individual and SHOP web portals. Comparative summary tools highlighting benefits, costs, quality, and provider accessibility should be developed with health literacy and reading comprehension levels in mind.

Eventually, a "single-door-entry" for both federal and state income qualified assistance programs (food stamps, education, health benefits) with a link to the Exchange would serve a valuable role. The work being done by the Office of the National Coordinator and their advisory committees will be important in developing a consensus around these standards.

Q: When enrollees move between public and private coverage, how should Illinois maintain continuity of health care – in plan coverage and in availability of providers, e.g. primary care physicians?

Q: What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

Ensuring continuity of care and coverage in a reformed health care environment is critical. Private payers are well suited to design programs to help ensure continuity of care and healthy outcomes for consumers, whether they are in a private or publicly funded delivery model. As a first step we encourage an analysis to determine what, if any continuity issues may exists in a reformed marketplace. Second, depending upon results of any analysis, a dialogue should take place between regulators and health insurers to determine if collaborative solutions exist or can be developed as needed.



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